MDR Tracking Number: M5-04-0205-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-16-03.

The IRO reviewed therapeutic exercises, office visits, joint mobilization, myofasical release and manual traction rendered from 07-03-03 through 07-15-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for therapeutic exercises, office visits, joint mobilization, myofasical release and manual traction. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-25-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
07-07-03	99080-73	$15.00	0.00	F	DOP	Rule 129.5	Relevant information was not submitted by the requestor in accordance with Rule 133.309 (g)(3) to confirm delivery of service for the fee component in this dispute. Therefore reimbursement is not recommended.
07-09-03	97750MT	$43.00	0.00	No EOB	$43.00	MFG MGR (I)(E)(3)	
TOTAL		$58.00					The requestor is not entitled to reimbursement.

This Decision is hereby issued this 24th day of February 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 07-03-03 through 07-15-03 in this dispute.

This Order is hereby issued this 24th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

November 21, 2003

Re: MDR #: M5-04-0205-01
IRO Certificate No.: IRO 5055

___has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
This female claimant received a crushing injury to her right hand on ___, mainly involving her right thumb and index finger, while on her job. She was evaluated by a doctor, and no fractures were reported. On 07/01/03, she sought chiropractic treatment.

Disputed Services:
Office visits, joint mobilization, moyfascial release, manual traction, and exercises during the period of 07/03/03 through 07/15/03.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the services in question were medically necessary in this case.

Rationale:
According to the *Treatment Guidelines for Chiropractic Quality Assurance and Practice Parameters*, published by TCA in 1994, treatment planning falls into two categories, short-term and

long-term, reference Chapter 8, Pages 124 and 125. Any symptoms that have remained unchanged after 8 to 10 weeks are considered chronic symptoms; those in between 0 and 8 weeks are considered sub-acute; and symptoms improving between 10 and 14 days are considered acute.

The patient actively began treatment and therapy on 07/01/03. The dates in question are between 07/03/03 and 07/15/03. According to the notes, a treatment plan was laid out by the treating doctor, and over this period of time, symptom levels and objective findings showed a response, though it was minimal. The treating doctor's treatment protocol was medically necessary and reasonable.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,